

Permanency Planning Instruments Technical Assistance Guide

Introduction and Background

With the passing of Senate Bill 368 in the 77th Legislative Session, the Health and Human Services Commission (HHSC) and designated health and human services agencies were charged by the state legislature with ensuring that a permanency plan is developed for each child who resides in an institution in Texas (Government Code, Subchapter D, Sections 531.151 to 531.163). This has been achieved by the collaborative efforts between HHSC and the Texas Department of Human Services (TDHS), the Texas Department of Protective and Regulatory Services (TDPRS), and the Texas Department of Mental Health and Mental Retardation (TDMHMR).

The legislation defined permanency planning as “ a philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship” (Government Code Section 531.151). The primary goal of permanency planning for children under age 18 is to reunite the child in the birth family or an alternative family. Permanency planning laws in the State of Texas are designed to ensure that children who are placed in institutions are placed there on a temporary basis. The objective of the permanency planning process is to ensure that the child will live in a long-term nurturing relationship with a family as soon as possible. To the maximum extent possible, the child will maintain a relationship with the birth family (or as limited by Children’s Protective Services or individual ages 18 – 22 and Legally Authorized Representative (LAR).

In accordance with the legislation HHSC agencies (as part of a team effort with families and providers) will review plans and supports for individual children semi-annually. HHSC will not require, mandate or otherwise make any child move to another setting without parental support and approval. It is not the intent of this legislation to replace parental choice or decision- making. In addition, HHSC will not support a child’s move without adequate community services and supports in place for the child and the family or support family. The intent of the bill is to ensure that families have ongoing opportunities to consider all options of care available for their children and to have the information necessary to select the supports and services that are in the best interest of the child. The following citation from Government Code Section 531.152 outlines the policy of the State of Texas:

“It is the policy of the state to strive to ensure that the basic needs for safety, security, and stability are met for each child in Texas. A successful family is the most efficient and effective way to meet those needs. The state and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of

being a part of a successful permanent family as soon as possible” (Government Code Section 531.152).

Permanency Planning Process

Permanency planning is not about moving a child within a predetermined timeframe, (such as within six months). While the legislation maintains placement of a child in an institution as temporary, the intent of the law and related state policies is meant to revolve around what is in the best interest of the child, considering the child’s development, health and well-being. **Permanency planning is an individualized, on-going process.**

The implementation and oversight of permanency plans must involve consideration for the child’s social, emotional, cognitive and physical development and well-being, a respect for parental choice, a realistic individualized inventory and appraisal of the support services that are needed and available, and an assessment of the support services that will need to be attained, including updated progress on efforts to attain those supports.

Permanency planning is a joint effort between families and professionals to offer family support, a permanent living arrangement and a nurturing parental relationship for every child with a disability. Current best practices adhere to the value that children belong in families. Generally, only in a family environment will children find the close and ongoing caregiver relationship that supports positive emotional growth and long term development. Although a family environment may not be an immediate possibility in many cases, in nearly all cases the plans should initially involve at a minimum, strategies to develop and/or ensure a consistent, nurturing, daily relationship with a parent or extended family member, or if family is not possible, a community volunteer, such as a ‘foster grandparent’.

HHSC believes that as each family is made aware of the availability of family-based services and supports, parental choice is enhanced. It is therefore our hope that each local agency and provider will strive to educate staff on current best practices and regulations and to share this information with families. Your willingness to participate in the development of alternatives, to stay current, and to adapt with the evolution of best practices will provide families with opportunities to make ongoing educated choices from a growing range of available services and supports to help ensure the best possible outcome for their child.

Guiding Principles for Permanency Planning

- 1. It is generally in the best interest of children to remain at home with their family.*
- 2. Remaining at home may be contingent on adequate support.*
- 3. Living in congregate care facilities is not considered to be an appropriate permanency planning option.*

4. *If a child cannot remain at home, priority attention should be given to a family-based alternative as the first priority.*
5. *Whenever placement in a residential alternative has occurred, the provision and coordination of services that will facilitate reunification of the child with his/her birth family should be given priority attention.*
6. *The specific elements of planning for permanency must be tailored to the individual circumstances of each child and family. For example some children who are already in care, strengthening their ties with their birth family by increasing the quality and quantity of involvement may be the most immediate permanency planning step. For other children, the permanency plan may include alternatives such as providing services in a long-term support-family home (non-CPS foster care). For other families the plan may call for a shared parenting arrangement where parental responsibilities are shared between a birth family and support family). For children where there is no parental involvement with the child, adoption planning or guardianship options should be assessed with the proper authorities.*

Permanency Planning Instrument for Children Under 18 Years of Age

Permanency plans must be developed for children whose parent(s) or guardian is seeking institutional placement for their child and for children who are currently residing in an institutional setting as defined by SB 368. The newly revised permanency planning instrument was developed to assist the planning team in complying with permanency planning requirements. [Appendix A]

Each section of the instrument is designed to capture specific information that will assist the team in achieving permanency for an individual child. Each section is an important piece of the total picture. Below is additional information to assist you in gathering and documenting the required information in the instrument.

Basic Instructions

When you respond to the questions in the instrument, assume the reader does not know this child or this family. Use information gathered from meeting the child, reviewing facility records, and speaking with the family and current caregivers to complete the documentation. Permanency planning is not a single event or meeting – it is a process that occurs over a period of time. Information gathered to complete this instrument should be gathered prior to the planning staffing meeting, some during the meeting, and some after the meeting. What is important is that all the information is gathered from appropriate sources and entered into the instrument. The instrument is meant to be used to collect information that is relevant to permanency to be used and integrated into the overall plan of service.

Information included in the instrument should be gathered from a variety of sources - especially from the family. Staff should make every effort to explain the process in a way that helps families want to participate. The family's participation and understanding of the process is critical to the success of the planning efforts. If the family declines to participate in the process, the staff permanency planning team members must continue to complete the instrument using whatever information they have available and knowledge of permanency planning principles. For children under the conservatorship of DPRS, the child's Child Protective Services (CPS) caseworker is the child's LAR and will participate in the planning process. The CPS caseworker will determine based on the court order, whether or not the family of a child in conservatorship of DPRS may participate in the planning process.

Valuable information for planning is also available in the child's records or can be gathered from observing the child and interviewing the child and caregivers. Permanency plans should be developed by team members who have talked with and observed the child.

Once the instrument is completed, a copy must be kept in the child's file and actions to be taken must be incorporated into the child's service plan. [Note: The intended use of this instrument is to provide guidance for development of the service plan. **The instrument is not intended for use as a questionnaire for an interview.** In order to prevent the instrument from being used as a guide to gather information from the family, you may want to develop another "discussion guide" that assists the facilitator in gather information from the family or LAR].

For the purpose of determining when reviews of permanency planning must take place, there must be a date by which the timeline begins. Although it was said earlier that the planning process is not a single event, the timeline begins on the date of the initial interdisciplinary planning staffing meeting. Six months from that date, the planning instrument must be updated by the team and another interdisciplinary staffing meeting, which includes the family/LAR, must be convened. Planning staff should begin gathering needed information to update the instrument in advance of the planning staffing meeting. Whenever possible, the family and the child, if appropriate, should participate in the interdisciplinary planning meeting in person. However, when it is not possible, staff should make every effort to gather information from the family by other means of communication (e.g. teleconferencing with family members during the staffing meeting, telephone contact to gather information prior to the interdisciplinary staffing meeting, etc.).

Once each planning instrument or review is completed, the Permanency Planning Review Screen (Screen 339) must be completed in the Client Assignment and Registration System (CARE). Be sure the data entered into CARE "matches" the information in the planning instrument. A copy of CARE Screen 249 indicating "approval status" should be kept in the individual's folder.

**** Important Note: The first time this planning instrument is used for a child, the team must complete the plan following instructions for "Initial" plans. The rationale for this is that previous plans developed do not include the information required in the new instrument. Some planners may decide to complete each subsequent review as if it were an initial plan.**

Section 1 Information for Permanency Planning

Section 1 is divided into 3 parts:

Part 1. Description of the Child – Who is this child?

A. Description of the child and the child's interpersonal interactions.

B. Describe the child's skills and abilities

C. Medical

Part 2. Permanency of Relationships

Part 3. Description of Continuity of Services

A. Continuity of Services and Service Needs When Living with Birth Family

B. Previous Placement Settings

Part 1. Description of the Child – Who is this child?

The purpose of this part is to describe the child with particular attention to the child's interpersonal needs so that the sections that follow can address the specific needs of the child. The section should provide an understanding of the child's abilities and needs to be used in planning to sustain or enhance a parent/child relationship and/or other significant attachment relationships in the child's life.

A. Description of the child and the child's interpersonal interactions

Describe the child, the child's personality characteristics, attributes, likes, dislikes, behavior, and reactions to others. This description should provide a "picture of the child" to the reader. If you are struggling with how to describe a child, you might consider describing the child in terms of social, emotional, or cognitive development. Examples of personality characteristics might include – shy, outgoing, friendly, affectionate, moody, easily distracted, highly energetic, curious, mischievous, seeks attention, doesn't like to be touched, argumentative, playful, etc.

Do not focus only on the aspects of the child's characteristics that resulted in the family's decision to seek another setting for their child to live. If you were going to describe your own child, or a child that you have a relationship with, how would you describe that child's personality, attributes, likes, dislikes, and behavior? Consider this as you complete this part.

B. Describe the child's skills and abilities

In order for the planning team to begin exploring activities to achieve permanency for a child, it is important to know about the physical and mental abilities of the child. If the child has a "diagnosis", it should be recorded in this part. If the child has been determined to have mental retardation, it should also be recorded, and if available, the level of mental retardation. If the level of mental retardation is not known, indicate such on the instrument.

If a child has a sensory impairment it must be indicated in this part, regardless of the degree of impairment. For example, a child may be "legally blind" or have a "visual impairment" with some vision. In both cases, the instrument should indicate the child has vision impairment. You can note the degree of impairment if known.

Include in this part what the child can do for her/himself. Give the child credit for what they can do for themselves. Don't be too quick to say they have no skills. Sometimes the child is able to do daily living activities by themselves, sometimes with assistance, or cooperates with the caregiver. Examples are:

- Dress without assistance /Assist in dressing/Cooperates with caregiver in dressing
- Eat without assistance/Use fingers to feed self or with an adapted spoon
- Able to walk/Able to move around in a wheelchair without assistance
- Uses words to express needs, wants, emotions/Uses gestures to express needs, wants, emotions
- Takes care of own grooming needs/assists in grooming self/cooperates during grooming activities
- Takes care of own toileting needs/Needs assistance with toileting, but let's staff know when needed

Also include in this part what the child needs help to do. Be specific and do not be too quick to use generalized terms such as "all areas of daily living".

C. Medical

It is important to consider the medical needs of a child when planning activities to achieve permanency for a child. Although this information may be available elsewhere in the child's records, it is important to record pertinent medical information in the planning instrument. Too often, this information is not provided and it is essential to understand and address medical needs if we are to have any success in returning a child home or finding an alternate family who can ensure the child's health and safety. If the required information is available in the records in a format that can be easily understood, a copy of the appropriate medical records may be attached to the planning instrument. If you choose to attach additional medical information, they become part of the instrument and should be submitted with the instrument if a copy is requested.

Part 2. Description of Permanency of Relationships

The purpose of this part is to describe the birth (or adoptive) parent/child relationship and the extent to which the family is a part of the child's life. If the child has been living away from home, how many visits have family members made in the last six months? Does the child ask for family members? How does the child behave during and after family visits? Documenting only "the family is very involved in their child's care" is too vague. A relationship involves reciprocal actions and reactions. This section should describe the frequency and nature of the child's opportunity to experience the nurturance of their family and the family's opportunity to provide it for the child.

This part should also identify any other significant emotional attachments in the child's life and the extent to which they are part of the child's current living arrangement. For example, if the child is currently living in a facility, there may be a particular staff person with whom the child is very attached and the attachment is reciprocated. Perhaps the child responds positively to this person and not others when needing comfort or when angry. Although it is assumed that all staff caring for a child care about the child's well-being, providing daily care of a child alone, even affectionate care, is not considered a "significant emotional attachment".

This section should also describe any cues that could be used as leads to facilitate the family/child relationship or support the possibility of new attachment relationships.

Part 3. Description of Continuity of Services

This part should address the circumstances and service availability when the child was living with his/her family, or in a subsequent placement, with an eye toward identifying any changes in circumstances or service availability which could be explored to facilitate returning home or to a family-based alternate living arrangement.

A. Continuity of Services and Service Needs when living with Birth Family

In order to facilitate a permanent living arrangement in a family setting, whether it is the child's home or another family's home, we have to look at what was happening when the child was living at home that prompted the family to look for another placement for their child. We must address the unmet needs of the child and family while living at home. Families need help in articulating what these needs are. Simply stating that the family could not care for the child anymore tells us nothing about what supports were not available and therefore need to be addressed in the plan. Even if the goal is not to return the child to their birth family, a support family may have the same support needs. The family may be able to express those needs with some detail if the discussion begins with the daily routine. You will have to facilitate this discussion, so that the family members understand the kinds of information that you want. This process is called a routine's based interview. The following is a list of questions that might be asked of a family (e.g., Sarah's family) to facilitate that discussion.

- Tell me what a typical day is (was) like with Sarah?
- What time does Sarah wake up in the morning? What is she like in the morning? Does she wake up happy, hungry?
- Tell me about breakfast time? How is breakfast time for you? How long does it take for Sarah to eat breakfast? What kinds of foods does Sarah eat? Does Sarah feed herself?
- How does Sarah get dressed for the day? Does she need help dressing? Are you able to manage dressing Sarah by yourself?

- What does Sarah do after she eats breakfast and gets dressed for the day? What does Sarah like to do? Does she play with toys? What kind of toys does she like? Does she watch TV?
- How long does Sarah stay occupied with an activity?
- How much supervision does Sarah need during this time?
- Tell me about lunch time. What's that like for Sarah and you?
- What does Sarah do during the afternoon? What is her typical routine?
- Do you have time for yourself during the day or time to get chores done?
- Tell me about when you take Sarah to the doctor's office. How does Sarah do in the car?
- Do you go on family outings? Does Sarah go also? How does that go?
- Tell me about dinner time. How does that go? What does Sarah do while you are preparing dinner?
- What does Sarah do in the evening?
- Are you able to get things done that you want or need to do during the day?
- What is bedtime like?
- What is bath time like?
- What time does Sarah go to bed at night? Does she go right to sleep? Does she sleep through the night?

From a typical day you might ask similar questions about a typical week or month.

- Are some days better than others?
- Are there patterns when things go better?

You must use your best listening techniques as the family responds to your questions. Some families need more probing than others do. If the family tells you about a particular part of the day that is problematic for them, you may have to probe a little deeper to get at what is needed. For example, if Sarah's mother tells us that bath time is difficult for her. You would want to probe deeper into what exactly makes it difficult? Is it that Sarah needs help getting into the bathtub and is too heavy for her mother to lift? Is it that Sarah does not like to take a bath and becomes combative during her bath? These questions may help us determine that Sarah needs some personal assistance support in order to return home or live with another family.

Note that the questions are focused around Sarah and the needs of the caregiver as it relates to caring for Sarah. This interview is not meant to probe into private aspects of a parent's life.

We also must take into account the age of the child when first placed and the fact that a child may have experienced many changes in placement, which can also affect the child's ability to make meaningful attachments to parental figures.

B. Previous Placement Settings

It is important to know when and how often a child has been moved from placement to placement and where those placements were. Reviewing the placement history may illuminate the cumulative losses of relationships in the child's life and increase awareness of the child's need for permanency. How the team will address permanency issues will depend on how long the child has been away from their birth family and how often a child has moved. Once you have the full picture of the number and type of placements the child has experienced, what does it tell you? Were the placement changes related to the child's condition or needs? Were they related to the caregiver's inability to care for the child? The answer to these questions are important to consider as the team chooses planning goals and activities.

Section 2 Support Planning Information

Section 2 is divided into 2 parts:

Part 1. Providing Information on Options

Part 2. Supports Needed

Part 1. Providing information on Options

The goal of permanency planning is to ensure that the child will benefit from a permanent living arrangement with an enduring and nurturing parental relationship as soon as possible. The purpose of this part is to document the information that was provided to the family regarding options and to identify their preferences and rationale. The informer must be able to describe for the family the options and how they offer a child an enduring parental relationship.

It is important that the informer be able to accurately explain the different family-based options available for planning for children under age 18. "Permanency Planning for Individuals Under Age 18 in Institutions" developed by HHSC require that the planning team choose one of the two planning goals that includes a family-based option to an institutional setting. Although the family may not desire either goal, the planning team must continue to develop a plan for a family-based option (Goal 1 or 2) in order to identify ways to move closer to the goal of a living arrangement which has a nurturing parental relationship as its primary feature. The team can document the family's disagreement with the chosen goal or decision to decline to discuss options with the team. Handouts explaining the different options are attached to the planning guide and can be shared with family members.

During the discussion with the family about the different options, you will need to take note of the fears or worries that family members express about the options. Some of their fears may be about something we can address by providing more information. For instance, parents might say, "If we can't take care of Sarah at home, and we love her, how could we expect another family to be able to do it?" In this example, what the family needs is information about family-based alternatives – shared parenting living arrangements and support families. They may become more open to the idea of another family if they can see that a support family's circumstances or level of support may be different than what the birth family experienced, and that may be what makes the situation different for them. They need to know that these families have chosen to care for a child with special needs, are trained to care for children like theirs, and will receive the supports necessary to ensure their child's wellbeing. In this instance, the team will want to ask the family if they would like more information about support families. The team can provide a handout (Attachment C) and ask if the family would like to be contacted by someone who can provide more detail and perhaps arrange a contact with a family who has chosen this option. The family member's responses will guide the facilitator on what might be possible next steps if any. In any event, the fact that the team must choose a family-based goal does not mean that the child will be moved without the family's permission.

Part 2. Supports Needed

This part is designed to capture the supports that the child and family (or family-based alternative) would need for the child to remain in their family home, return to the family home or move to a family-based alternative. Information that would assist the team in determining the necessary supports will be gathered from a variety of sources – the child, the family, staff caregivers, child records, observations, etc.

The instrument must include a brief description of the frequency and intensity of each needed support and whether or not training associated with each need is necessary for the family. For example, if the team determines that "Sarah" would continue to need behavior intervention if she were to move back home, the team must recommend the frequency and intensity of the needed intervention. The plan must also indicate whether or not the family would need some training in order to work on Sarah's behavior at home.

Once the team has determined that a support is needed, it must also be determined whether or not access to that support is currently "underdevelopment" or "available". Using the above example, the team must determine if behavior intervention is currently available to her in her family's home. If Sarah does not yet have a waiver slot, funding for behavior intervention may not be currently available. In this example, the access to behavior intervention would be "underdevelopment". TDMHMR considers a needed service as "underdevelopment" if the child's name has been placed on the waiting list for waiver services. However, if there were another funding source to pay for that support in the home, then the support would be listed as available (e.g., medical

services available through Medicaid, CCP, etc.) Some supports may be available and some underdevelopment, depending on the resources of the family, the MRA, and other community resources.

The following are the list of supports and definitions of each that the team will be considering:

Architectural Modifications: Includes widening of doorways, lowering of counters, ramps, bathroom modifications, kitchen modifications, etc. that allow access to a person's home. Does not include modifications to public facilities.

Behavioral Intervention for Child or Training for Family: Includes the services of a behavioral specialist or therapist in developing a plan of intervention and training of the family in behavioral intervention as related to that child's needs for behavioral intervention.

Child Care or After School Care: For additional child care needs above and beyond normal child care needs for children 13 years old and under and those 14 years old and older; i.e., extra supervision, one-on-one supervision while the parent is at work.

Crisis Intervention: Supports for child and family to prevent institutionalization due to life threatening situations that are documented to cause impending out of home placement within a 72-hour time period with no supports.

Durable Medical Equipment: Adaptive aids and other disability equipment needs that increase independence in daily life. Also includes medical supplies that are needed on a regular basis. Wheelchairs, communication devices, medical supplies, adaptive eating equipment, etc. (reference to Medicaid definition of DME).

Transportation: Transportation that is available to the general public and contracted with a private individual; i.e., bus, taxi, per mile or trip contract, etc.

Family Based Alternative: Provide assistance in the referral and support for placement in alternate community program in a family, e.g., alternate family, shared parenting, foster care, open adoption.

In Home Health Care Services: Identified nursing needs to be provided within the home setting.

Mental Health Services, including Counseling: Evaluation and identified mental health support needs including evaluation, testing, counseling, medication supports, behavioral interventions.

Night Time Person: Staff available for supervisory needs for health and safety identified needs, assistance in going to bathroom, turning to prevent bed sores, prevent running away, etc.

Ongoing Medical Services: Medical services that have been identified to be regular monitoring services due to the medical needs of the child, blood levels, regular follow-up visits to monitor condition or medical need, access to medical specialists.

Personal Assistance Support for Activities of Daily Living: Assistance with daily living needs including bathing, grooming, eating, mobility, etc.

Respite for Family In Home: Periodic relief of caregiving that is provided in the home of the individual. (hourly or daily)

Respite for Family Out of Home: Periodic relief of caregiving that is provided in another setting other than the person/family home. (hourly or daily)

Special Equipment: Equipment that has been identified by the appropriate licensed professional for the person to be independent in daily living. Wheelchairs, communication devices, specialized eating utensils, etc.

Specialized Therapies (e.g., Occupational Therapy, Physical Therapy, Speech Therapy): Evaluations and therapy services that are provided by the appropriate licensed therapist.

Specialized Transportation: Available public transportation that provides services to those with disabilities.

Training to Assist Person in Independent Living or Assist Family in Providing Proper Care for Unique Needs: Identified training to improve or increase the independence of the individual to live at home. Includes dressing, bathing, eating, completing chores, making bed, cooking, etc. Training of the family in how to take care of the daily needs of the child including bathing, medical care, feeding, etc.

Volunteer Advocate: A person selected by the parent or guardian, an adult relative, or a representative of a child advocacy group not employed by or under contract with the institution in which the individual resides to assist in permanency planning for individuals under age 22 residing in ICF/MR, state school, receiving waiver services of residential support, supervised living or supported living, or residing with four or more unrelated individuals.

Section 3. Action Plans

Section 3 has one part:

Part 1: Planning

Part 1: Planning

The purpose of this section is to identify any actions that can facilitate changes (a change in placement or within the current living arrangement) that could result in an enduring parent-child relationship.

There are activities that may be able to occur in the interim, before a child can return home or another family-based alternative can be achieved. The activities can occur concurrently with the development of supports as identified in Section 2. Examples are listed in the planning instrument, but are not meant to be an exhaustive list. There may be activities that you want to explore that you do not necessarily have the authority to implement. For example, by checking "Explore feasibility of changing facility staffing pattern to foster attachments between the child and primary caregivers," the planning team has determined that changing staffing patterns may be beneficial to

the child. By checking that activity, the planning team is making a commitment to “explore the feasibility” of that occurring. It does not “commit” the residential provider to implement it if it is clearly not feasible.

Activities in the first column are those to enhance the child’s attachment relationship with others while in the current setting. For children without access to funding sources that would provide supports in a family-based option or for children whose families have chosen for their child to remain in the current setting, there may be things we can do to improve the number and quality of the child’s most important relationships. Once a child is residing in an “institutional setting”, the residential provider becomes responsible for the planning process, which includes the case management activities that need to occur. Case management activities may include looking for funding sources in order to implement some of the activities identified as needed. For example, a family may live a long distance from the residential facility and have limited resources to visit their child very often or at all. If the family indicates that they would like to visit more often, then the child’s case manager should explore ways to facilitate more visits from the family. This may be accomplished by using the residential provider’s discretionary funds, if available, or contacting benevolent organizations for funding to buy bus tickets or gasoline and lodging. Be creative. Explore any and all community resources to make things happen.

Activities in the second column are those to increase support for returning to live with the birth family, should this be the goal of the planning team. For example, a family may need training regarding the care of their child before their child returns home. In this example, the team would identify the support needed for training for the family in Section 2. The team should explore the feasibility of this occurring while the child resides in the facility by allowing the family to observe and practice daily care for their child. Another example may be that a family needs more information about behavior management. This information can be gathered for the family and provided or perhaps even a referral for training in behavior management is feasible. The key is, be creative.

Activities in the third column are those to increase support for an alternate living arrangement that includes an enduring parental relationship. Understanding and being able to inform families about alternate family arrangements is often difficult for team members who have not had experience with these options or an opportunity to learn about them. It is often our inability to represent an accurate picture of these choices that influences families to “discount” this as a viable option for their child. The activities listed in the instrument in this column may be activities that you do not feel competent to implement. Therefore, a contact number is provided so that you can call to get accurate information and possibly assistance with implementation of selected activities (e.g. explore options for parents to contact other families who use alternate family care.)

Each column of the action plan requires the planning team to identify specific activities and determine who will carry out the activities listed. It should be assumed that it is

the responsibility of the case manager to facilitate the activities, whether it be to acquire information to share with families, facilitate a referral to other professionals, or seek funding to increase family visits. Although it is the function of the case manager to facilitate the activities, it does not financially “obligate” the residential provider for providing something that is not required by law (e.g. pay travel for the family to visit their child or travel to visit an alternate family). The activities stimulated by this instrument need to be built into the overall plan of services.

Section 4. Participants

Indicate participants in the planning process. The planning instrument is a record of all planning activities, including but not exclusively, information gathered at a planning team meeting. Therefore, some of the participants may have provided information during a team meeting that included the child or family members, while other information may have been gathered from review of the child’s records and interviews with staff caring for the child, or in conversations with the parents other than in meetings. Regardless of when and how the information was gathered, all individuals who provided information for the planning documentation must be included.

Permanency Planning Instrument for Individuals 18 Through 21 Years of Age

Permanency plans must be developed for individuals 18 to 22 years of age who are or whose LAR is seeking institutional placement and for those individuals 18-22 years of age who are currently residing in an institutional setting as defined by SB 368. The newly revised permanency planning instrument was developed to assist the planning team in complying with permanency planning requirements. [Appendix B]

Each section of the instrument is designed to capture specific information that will assist the team in achieving permanency for the individual. Each section is an important piece of the total picture. Below is additional information to assist you in gathering and documenting the required information in the instrument.

Basic Instructions

When you respond to the questions, assume the reader does not know this individual or this family/legally authorized representative (LAR). Use information gathered from the individual, reviewing facility records, and speaking with the family and current caregivers to complete the documentation. Permanency planning is not a single event or meeting – it is a process. Some portions of this instrument may be completed prior to the planning staffing meeting, some during the meeting, and some after the meeting. What is important is that all the information is gathered from appropriate sources. The instrument is meant to be used to collect information that is relevant to permanency to be used and integrated into the overall plan of services.

Permanency planning for young adults should incorporate the principles and practices of self-determination. A family setting may not be the choice or best option for a young adult. Permanency planning for many older children and young adults often centers on a less restrictive, more community-based setting. The focal piece of the planning process should be based on the choice of the individual and/or their guardian. Information included in the instrument should be gathered from a variety of sources. Staff should make every effort to explain the process in a way that helps families want to participate. If the LAR declines to participate in the process, the staff permanency planning team members must continue to complete the instrument using whatever information they have available and knowledge of permanency planning principles.

Valuable information for planning is also available in the individual's records or can be gathered from observing the individual and interviewing caregivers. Permanency plans should be developed by team members who have talked with and observed the individual.

Once the planning instrument is completed, a copy must be kept in the individual's file and actions to be taken must be incorporated into the individual's service plan. [Note: The intended use of this instrument is to provide guidance for development of the service plan. **The instrument is not intended for use as a questionnaire for an interview.** In order to prevent the instrument from being used as a guide to gather information from the family, you may want to develop another "discussion guide" that assists the facilitator in gathering information from the family/LAR].

For the purpose of determining when reviews of permanency planning must take place, there must be a date by which the timeline begins. Although it was said earlier that the planning process is not a single event, the timeline begins on the date of the initial interdisciplinary planning staffing meeting. Six months from that date, the planning instrument must be updated by the team and another interdisciplinary staffing meeting, which includes the family/LAR, must be convened. Planning staff should begin gathering needed information to update the instrument in advance of the planning staffing meeting. Whenever possible, the family should participate in the interdisciplinary planning meeting in person. However, when it is not possible, staff should make every effort to gather information from the family/LAR by other means of communication (e.g. teleconferencing with family members/LAR during the staffing meeting, telephone contact to gather information prior to the interdisciplinary staffing meeting, etc.).

Once each planning instrument or review is completed, the Permanency Planning Review Screen (Screen 339) must be completed in the Client Assignment and Registration System (CARE). Be sure the data entered into CARE "matches" the information in the planning instrument. A copy of CARE Screen 249 indicating "approval status" should be kept in the individual's folder.

**** Important Note: The first time this planning instrument is used for an individual, the team must complete the plan following instructions for "Initial" plans. The rationale for this is that previous plans developed do not include the information required in the new instrument. Some planners may decide to complete each subsequent review as if it were an initial plan.**

Section 1 Information for Permanency Planning

Section 1 is divided into 3 parts:

Part 1. Description of the Individual – Who is this person?

A. Description of the individual and the individual's interpersonal interactions.

B. Describe the Individual's skills and abilities

C. Medical

Part 2. Permanency of Relationships

Part 3. Description of Continuity of Services
A. Previous Placement Settings

Part 1. Description of the Individual – Who is this person?

The purpose of this part is to describe the individual with particular attention to the individual's interpersonal needs so that the sections that follow can address the specific needs of the individual. The section should provide an understanding of the individual's abilities and needs to be used in planning to sustain or enhance significant attachment relationships in the individual's life.

A. Description of the individual and the individual's interpersonal interactions

Describe the individual, the individual's personality characteristics, attributes, likes, dislikes, behavior, and reactions to others. This description should provide a "picture of the individual" to the reader. If you are struggling with how to describe an individual, you might consider describing the person in terms of social, emotional, or cognitive development. Examples of personality characteristics might include – shy, outgoing, friendly, affectionate, moody, easily distracted, highly energetic, curious, mischievous, seeks attention, doesn't like to be touched, argumentative, playful, etc.

Do not focus only on the aspects of the individual's characteristics that resulted in the decision to seek another setting for them to live. If you were going to describe your family member, or an individual that you have a relationship with, how would you describe their personality, attributes, likes, dislikes, and behavior? Consider this as you complete this part.

B. Describe the individual's skills and abilities

In order for the planning team to begin exploring activities to achieve permanency for an individual, it is important to know about the physical and mental abilities of the individual. If the individual has a "diagnosis", it should be recorded in this part. If the individual has been determined to have mental retardation, it should also be recorded, and if available, the level of mental retardation. If the level of mental retardation is not known, indicate such on the instrument.

If an individual has a sensory impairment it must be indicated in this part, regardless of the degree of impairment. For example, an individual may be "legally blind" or have a "visual impairment" with some vision. In both cases, the instrument should indicate the individual has vision impairment. You can note the degree of impairment if known.

Include in this part what the individual can do for her/himself. Give the individual credit for what they can do for themselves. Don't be too quick to say they have no skills. Sometimes the individual is able to do daily living activities by themselves, sometimes with assistance, or cooperates with the caregiver. Examples are:

- Dress without assistance /Assist in dressing/Cooperates with caregiver in dressing
- Eat without assistance/Use fingers to feed self or with an adapted spoon
- Able to walk/Able to move around in a wheelchair without assistance
- Uses words to express needs, wants, emotions/Uses gestures to express needs, wants, emotions
- Takes care of own grooming needs/assists in grooming self/cooperates during grooming activities
- Takes care of own toileting needs/Needs assistance with toileting, but let's staff know when needed

Also include in this part what the individual needs help to do. Be specific and do not be too quick to use generalized terms such as "all areas of daily living".

C. Medical

It is important to consider the medical needs of an individual when planning activities to achieve permanency. Although this information may be available elsewhere in the individual's records, it is important to record pertinent medical information in the planning instrument. Too often, this information is not provided and it is essential to understand and address medical needs if we are to have any success in returning the individual to their family home or finding an alternate living arrangement where caregivers can ensure the individual's health and safety. If the required information is available in the records in a format that can be easily understood, a copy of the appropriate medical records may be attached to the planning instrument. If you choose to attach additional medical information, they become part of the planning instrument and should be submitted with the instrument if a copy is requested.

Part 2. Description of Permanency of Relationships

The purpose of this part is to identify any significant emotional attachments in the individual's life and the extent to which they are part of the individual's life. If the individual has been living away from their family home, how many visits have family members/LAR made in the last six months? Does the individual ask for family members? How does the individual react to visits with family members or LAR? Documenting only "the family is very involved in the individual's care" is too vague. A relationship involves reciprocal actions and reactions. This section should describe the

frequency and nature of the individual's opportunity to experience the nurturance of their family and the family's/LARs opportunity to provide it for their family member.

This part should also identify any other significant emotional attachments in the individual's life and the extent to which they are part of the individual's current living arrangement. For example, if the individual is currently living in a facility, there may be a particular staff person with whom he/she is very attached and the attachment is reciprocated. Perhaps the individual responds positively to this person and not others when needing comfort or when angry. Although it is assumed that all staff caring for an individual care about the person's well-being, providing daily care of the individual alone is not considered a "significant emotional attachment".

This section should also describe any cues that could be used as leads to facilitate a continued relationship with the individual's family members or support the possibility of new relationships.

Part 3. Description of Continuity of Services

This part should identify all of the settings in which the individual has lived since leaving their family's/LAR's home

A. Previous Placement Settings

It is important to know when and how often the individual has been moved from placement to placement and where those placements were. Reviewing the placement history may illuminate the cumulative losses of relationships in the individual's life and increase awareness of the individual's need for permanency. We must also take into account the age of the individual when first placed out of the family home. How the team will address permanency issues will depend on how long the individual has been away from their birth family and how often they have been moved. Once you have the full picture of the number and type of placements the individual has experienced, what does it tell you? Were the placement changes related to the individual's condition or needs? Were they related to the caregiver's inability to care for the individual? The answer to these questions are important to consider as the team chooses planning goals and activities.

Section 2 Support Planning Information

Section 2 is divided into 2 parts:

Part 1. Providing Information on Options

Part 2. Supports Needed

Part 1. Providing information on Options

The goal of permanency planning is to ensure that the individual will live where the individual, or individual's LAR, if appropriate, chooses and enable the individual to maintain significant relationships of affection and attachment. The purpose of this part is to document the information that was provided to the individual and the individual's LAR, if appropriate, regarding options and to identify their preferences and rationale. The informer must be able to describe the options and how they do or do not offer an individual an opportunity to maintain significant relationships.

It is important that the informer be able to accurately explain the different family-based options available for planning for individual's 18-22 years of age. "Permanency Planning for Individuals 18 through 21 in Institutions" developed by HHSC outline four planning goals available to the planning team for consideration. It also outlines planning procedures for this age group that take into consideration laws that require presumption that individuals who are at least 18 years of age are considered competent unless determined otherwise by a court and appointed a guardian. For individuals 18 to 22 years of age, permanency planning should invoke the person-directed planning process. The planning represents for this population a required consideration of the domain in which the individual defines where he/she will live and the type of relationship the individual will have with his/her family. It should include as an objective, if not the primary or sole objective, where the individual prefers to live and age-appropriate activities regarding maintenance of the relationship with family. Different than for planning for children under 18 years of age, individuals 18-22 years of age have available the options to plan to move to another facility or to remain in the current residence.

If the individual's LAR declines to participate in the planning process, the team can document the LAR's decision to decline to discuss options with the planning team. However, the planning team must continue with the planning process and complete the information on the planning instrument. Handouts (Appendix C) explaining the different options are attached to the planning guide and can be shared with family members.

During the discussion with the family/LAR about the different options, you will need to take note of the fears or worries that family members express about the options. Some of their fears may be about something we can address by providing more information. The team can provide a handout (Appendix C) and ask if the family/LAR would like to be contacted by someone who can provide more detail and perhaps arrange a contact with a family who has chosen a particular option. The family member's/LAR's responses will guide the facilitator on what might be possible next steps if any.

Part 2. Supports Needed

This part is designed to capture the supports that the individual or the individual's family (or family-based alternative) would need for the individual to remain in their

family home, return to the family home, move to a family-based alternative, or move to another facility. Information that would assist the team in determining the necessary supports will be gathered from a variety of sources – the individual, the family, staff caregivers, records, observations, etc. If a planning Goal 4 is chosen, which is to remain in the current residence, the planning team does not have to identify needed supports.

If a planning Goal of 1, 2, or 3 is chosen, the instrument must include a brief description of the frequency and intensity of each needed support and/or what training associated with each need is necessary for future caregivers. For example, if the team determines that “Sarah” would continue to need behavior intervention if she were to move from an ICF/MR facility to a Medicaid waiver group home near her family, the team must recommend the frequency and intensity of the needed intervention.

Once the team has determined that a support is needed, it must also be determined whether or not access to that support is currently “underdevelopment” or “available”. Using the above example, the team must determine if behavior intervention would be available to Sarah if she were to move from an ICF/MR facility to a waiver group home. If Sarah does not yet have a Medicaid waiver slot, funding for behavior intervention may not be currently available. In this example, the access to behavior intervention would be “underdevelopment”. TDMHMR considers a needed service as “underdevelopment” if the individual’s name has been placed on the waiting list for Medicaid waiver services. However, if there were another funding source to pay for a support, other than through Medicaid waiver services, then the support would be listed as available (e.g., medical services available through Medicaid, CCP, etc.) Some supports may be available and some underdevelopment, depending on the resources of the family/LAR, the MRA, and other community resources.

The following are the list of supports and definitions of each that the team will be considering:

Architectural Modifications: Includes widening of doorways, lowering of counters, ramps, bathroom modifications, kitchen modifications, etc. that allow access to a person’s home. Does not include modifications to public facilities.

Behavioral Intervention for Child or Training for Family: Includes the services of a behavioral specialist or therapist in developing a plan of intervention and training of the family in behavioral intervention as related to that child’s needs for behavioral intervention.

Child Care or After School Care: For additional child care needs above and beyond normal child care needs for children 13 years old and under and those 14 years old and older; i.e., extra supervision, one-on-one supervision while the parent is at work.

Crisis Intervention: Supports for child and family to prevent institutionalization due to life threatening situations that are documented to cause impending out of home placement within a 72-hour time period with no supports.

Durable Medical Equipment: Adaptive aids and other disability equipment needs that increase independence in daily life. Also includes medical supplies that are needed on a regular basis. Wheelchairs, communication devices, medical supplies, adaptive eating equipment, etc. (reference to Medicaid definition of DME).

Transportation: Transportation that is available to the general public and contracted with a private individual; i.e., bus, taxi, per mile or trip contract, etc.

Family Based Alternative: Provide assistance in the referral and support for placement in alternate community program in a family, e.g., alternate family, shared parenting, foster care, open adoption.

In Home Health Care Services: Identified nursing needs to be provided within the home setting.

Mental Health Services, including Counseling: Evaluation and identified mental health support needs including evaluation, testing, counseling, medication supports, behavioral interventions.

Night Time Person: Staff available for supervisory needs for health and safety identified needs, assistance in going to bathroom, turning to prevent bed sores, prevent running away, etc.

Ongoing Medical Services: Medical services that have been identified to be regular monitoring services due to the medical needs of the child, blood levels, regular follow-up visits to monitor condition or medical need, access to medical specialists.

Personal Assistance Support for Activities of Daily Living: Assistance with daily living needs including bathing, grooming, eating, mobility, etc.

Respite for Family In Home: Periodic relief of caregiving that is provided in the home of the individual. (hourly or daily)

Respite for Family Out of Home: Periodic relief of caregiving that is provided in another setting other than the person/family home. (hourly or daily)

Special Equipment: Equipment that has been identified by the appropriate licensed professional for the person to be independent in daily living. Wheelchairs, communication devices, specialized eating utensils, etc.

Specialized Therapies (e.g., Occupational Therapy, Physical Therapy, Speech Therapy): Evaluations and therapy services that are provided by the appropriate licensed therapist.

Specialized Transportation: Available public transportation that provides services to those with disabilities.

Training to Assist Person in Independent Living or Assist Family in Providing Proper Care for Unique Needs: Identified training to improve or increase the independence of the individual to live at home. Includes dressing, bathing, eating, completing chores, making bed, cooking, etc. Training of the family in how to take care of the daily needs of the child including bathing, medical care, feeding, etc.

Volunteer Advocate: A person selected by the parent or guardian, an adult relative, or a representative of a child advocacy group not employed by or under contract with the institution in which the individual resides to assist in permanency planning for individuals under age 22 residing in ICF/MR, state school, receiving waiver

services of residential support, supervised living or supported living, or residing with four or more unrelated individuals.

Section 3. Action Plans

Section 3 has one part:

Part 1: Planning

Part 1: Planning

The purpose of this section is to identify any actions that can facilitate changes (a change in placement or within the current living arrangement) that could facilitate maintaining significant relationships of affection and attachment.

There are activities that may be able to occur in the interim, before an individual can move to a setting of choice. The activities can occur concurrently with the development of supports as identified in Section 2. Examples are listed in the planning instrument, but are not meant to be an exhaustive list. There may be activities that you want to explore that you do not necessarily have the authority to implement. For example, by checking "Explore feasibility of changing facility staffing pattern to foster attachments between the individual and primary caregivers," the planning team has determined that changing staffing patterns may be beneficial to the individual. By checking that activity, the planning team is making a commitment to "explore the feasibility" of that occurring. It does not "commit" the residential provider to implement it if it is clearly not feasible.

Activities in the first column are those to enhance the individual's attachment relationship with others while in the current setting. For individual's without access to funding sources that would provide supports in another setting or for individuals who will remain in the current setting (as chosen by the individual or LAR, if appropriate), there may be things we can do to improve the number and quality of the individual's most important relationships. Once an individual is residing in an "institutional setting", the residential provider becomes responsible for the planning process, which includes the case management activities that need to occur. Case management activities may include looking for funding sources in order to implement some of the activities identified as needed. For example, a family may live a long distance from the residential facility and have limited resources to visit their family member very often or at all. If the family indicates that they would like to visit more often, then the individual's case manager should explore ways to facilitate more visits from the family. This may be accomplished by using the residential provider's discretionary funds, if available, or contacting benevolent organizations for funding to buy bus tickets or gasoline and lodging. Be creative. Explore any and all community resources to make things happen.

Activities in the second column are those to increase support for living in a community setting of the individual's/LAR's choosing. For example, an LAR may want the individual

to move from the current ICF/MR facility to another closer to family members until Medicaid waiver services become available. In this example, the team may want to identify having the individual's LAR visit potential alternate settings. If an individual does not have an LAR or active family member, the team may want to recommend that a volunteer advocate become involved.

Each column of the action plan requires the planning team to identify specific activities and determine who will carry out the activities listed. It should be assumed that it is the responsibility of the case manager to facilitate the activities, whether it be to acquire information to share with families, facilitate a referral to other professionals, or seek funding to increase family visits. Although it is the function of the case manager to facilitate the activities, it does not financially "obligate" the residential provider for providing something that is not required by law (e.g. pay travel for the family to visit the individual or travel to visit an alternate setting). The activities stimulated by this instrument need to be built into the overall plan of services.

Section 4. Participants

Indicate participants in the planning process. The planning instrument is a record of all planning activities, including but not exclusively, information gathered at a planning team meeting. Therefore, some of the participants may have provided information during a team meeting that included the family members, while other information may have been gathered from review of the individual's records and interviews with staff caring for the individual, or in conversations with the family/LAR other than in meetings. Regardless of when and how the information was gathered, all individuals who provided information for the planning documentation must be included in the following list of participants.

FAMILY-BASED ALTERNATIVES

Attachment C

Circumstances beyond a family's control sometimes require the out-of-home placement of children with disabilities. Family-based alternatives offer families choice. Research has shown that children have a better chance of thriving and meeting their potential when they grow up in families. We know that children's need for attachment and security can best be met in a family.

Family-based alternative options can meet a variety of family support needs. Children can be placed in an alternate family and yet remain an integral part of the birth family's life, thereby enriching the lives of the entire family.

If desired, birth families participate in all the planning and decision-making involved in the alternative family option. In addition, families can remain a central part of the child's life even while the child live with another family. Birth families even participate in the selection of the alternate family and are encouraged to maintain regular contact with their child.

Family-based options come in Many "sizes." Because families and children are all different, no "one size fits all" program will work. Under a shared-parenting relationship, children may spend equal time with the alternative family and the birth family. This arrangement allows for extended periods of respite enabling the birth family time to rest and re-group. At the opposite end of the spectrum, a child may live with an alternative family in a long-term relationship yet continue to see his or her birth family for visits, outings, holidays, etc.

There is no right or wrong combination. Whatever works best for the child, the birth family and the alternative family is the ultimate goal.

In 2001, legislation was passed in Texas that requires the state to begin to develop and implement a system of family-based alternatives for children residing in Texas institutions. It is hoped that by creating this system, families will have real options when faced with the possibility of out-of-home placement for their child. Family-based alternatives have been used successfully for years in other states to support families caring for children with disabilities.

What are family-base alternatives?

- **Support to return home**
- **Another family to share in a child's care – called Shared Parenting**
- **An alternate family to provide full time care – called a Support Family**

Creating family-based alternatives requires simultaneous activity in three areas:

1. Collaborating with **birth families** to explore possible alternatives to residential care for a child with a disability.
2. Recruiting and preparing **Support Families** or **Shared Parenting** arrangements to provide a home for children who can't live with their birth families or who can't live with their birth families full time.
3. Linking together people, supports, and activities of **community agencies as partners** in helping families and children to thrive.

The first goal to be considered is exploring the possibility of finding adequate supports to enable a child to return home. If that is not possible, then the second goal to be considered is the possibility of finding a Shared Parenting arrangement or a Support Family who is chosen by the birth family to care for their child.

What is Shared Parenting?

Shared Parenting is an arrangement in which a family is recruited and trained to help a birth family in caring for their child with disabilities as a means of preventing conditions that lead to residential placement. Shared Parenting is similar to arrangements that occur naturally, for example, when families use their extended kin to care for a child part time or when parents divorce and care is shared between two households. When families with children with disabilities find that their own network of family is unable to help, sometimes a Shared Parenting arrangement can fill a similar role. Shared Parenting arrangements are distinguished by the following features:

- Shared Parenting families are specifically recruited for children with disabilities.
- A Shared Parenting family is paid as a caregiver but care is provided in a family home.
- A recruited family is chosen by the birth family to provide a part-time home for a child on a regular basis scheduled when the birth family needs and wants that kind of help.
- The amount of time shared and the conditions under which care is shared between two families can vary with family's circumstances and preferences.
- Families who provide Shared Parenting are carefully screened, certified, and monitored by a community agency who is responsible for assuring the child's well-being through supervision and support.
- Shared Parenting arrangements include a negotiated agreement between birth parents and shared parents outlining the schedule of care and describing mutual decisions about how to share care. Shared Parenting can be an innovative way to provide practical assistance to a birth family while enabling a child to continue to enjoy the benefits of family life.

What is a Support Family?

A Support Family is a family who has been recruited, carefully selected, fully prepared, and paid to provide care for a child with a disability. Support Families are distinguished from traditional foster care by several unique features:

- Support Families are recruited specifically for children with disabilities.
- Support Families are asked to make long-term commitments rather than provide short-term care.
- Birth families can voluntarily choose to use a Support Family without giving up their rights.
- Support Families receive training and preparation specifically for the child who will be placed with them prior to the placement.
- Support Families are carefully matched with children and with their birth families so that the families can work collaboratively for the child.
- Adequate time is taken to prepare the Support Family in order to assure the child's well-being and to ensure the possibility of a long-term arrangement.

A Support Family is different way to arrange caregiving that offers the reliability of a paid caregiver and the lifestyle of a family when birth parents are unable to care for a child.

Guidelines for Self Assessment of Permanency Plans

These guidelines have been recommended by HHSC for use in assessing whether or not permanency planning processes meet, at a minimum, statutory requirements.

1. There are two major issues involved in Texas' permanency planning policy. One is parental authority in decision-making about their child. The other is the daily relational life of the child. The goal of permanency is "a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship." The task of permanency planning is to create family support or family-based alternatives of sufficient quality and quantity that birth families will find them worthy of their approval.

Q1: Does the plan identify the extent to which the current living arrangement has as its primary feature an enduring and nurturing parental relationship?

2. State policy recognizes that parents are a valued and integral part of the process, and requires agencies to "encourage parents to participate in all decisions affecting their children and respect the authority of parents, other than parents whose parental rights have been terminated, to make decisions regarding their children."

Q2a: Does the plan identify the nature of the parents' current availability, ability, or willingness to fulfill the role of an enduring and nurturing relationship in a meaningful way in their child's daily life?

Q2b: Does the plan identify any ways in which to assist the parent(s) to increase their availability, ability, or willingness to participate in their child's daily life?

Q2c: Does the plan identify the parents' voluntary willingness to enable a surrogate figure to provide an enduring relationship with their child?

3. We anticipate that there may be a number of situations where there is neither the availability of the parent to play a nurturing role in the child's daily life or the interest in finding an alternative way for that role to be played.

Q3a: Does the plan identify specific positive ways in which any disparity between the parent's preferences and the child's need to live in a family might be lessened?

Q3b: Does the plan identify time frames and a progression of activities that might lead to changes in the parents' perspective?

4. We acknowledge that the state's policy of permanency planning involves a major shift in the way we have worked with families. Past experience may have been inconsistent with current policy. We recognize that many of the changes that need to occur require more activities on our part to support families and create family-based alternatives.

Q4: Does the plan specifically identify activities that will occur to change the availability of support to enable the outcome of family life for the child?